Sample 2-1-2010

School District Name

SAMPLE Occupational Therapy Evaluation/Reevaluation

Student Name: _____ Date of Birth:_____

Chronological Age:_____ Date of Evaluation:_____

School:_____ Therapist:_____

Medicaid Number: _____

Background Information:

Evaluation Procedures:

Cognitive/Behavior/Communication:

Neuromuscular Control/Sensory Processing:

Fine Motor/Visual Motor:

Self-Help:

Summary/Recommendations:

_____ _____

Occupational Therapist Signature /Title Date